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ABSTRACT

Clinical assimilation of the various methods of family therapy, while maintaining an analytic, self-psychology perspective gave rise to Complementary Narcissism's novel system's perspective of the individual in context. While Complementary Narcissism Theory is applicable to all families, its interventions are most effective with those families who evidence a moderate to high ability to delay gratification in service of a larger reward later. Individual health requires being relatively low in omnipotence or in grandiosity, and in being able to move, when desired, quickly and smoothly between healthy presentations, i.e. low levels of omnipotence and grandiosity. In this self complementarity, the individual is able to have holistic intrapsychic experience and to enter into relationships based upon this strength. Without this capacity, the individual will relate to others who are attracted to dysfunctional presentations of grandiosity and omnipotence, and out of dysfunctional complementarity, rather than out of the strength of intrapsychic wholeness. Consistent with analytic family psychologies this approach goes beyond the family's presenting complaint, the precipitant, and specific behaviors, to understand the etiology of the individuals and of the family itself. At the same time that the origin of a family system is describing the way individuals and their histories influence the system, data is being gathered concerning the influence of the present family of creation, once formed, on the individuals. (ABL)

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Division 43: Family Psychology

Complementary Narcissism Theory: A Family Systems Application of Self Psychology

Part 1: Theory

Craydon D. McDonald, Ph.D.

CG024739

A symposium presented to the
100th Annual Convention of the
American Psychological Association
Washington, D.C.

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A Zen perspective on marriage:
"When one dances the other applauds."

Chinese proverb

omnipotence: adj. 1. (theory of) the hypothesis that in late infancy and early childhood the individual literally regards self as able to control all the persons around. 2. having virtually unlimited authority or influence. 3. the implicit expectation or expectancy of the very young child that wishes fulfillment themselves. No conscious generalization is involved. **syn** see power.

grandiosity: : adj. 1. magnificent: imposing; awe-inspiring 2. impressive because of uncommon largeness, scope, effect, or grandeur. 3. characterized by affectation of grandeur or splendor or by absurd exaggeration. **syn** see grand.

from

English and English
A comprehensive dictionary of psychological and psychoanalytical terms
and
G. & C. Merriam
Webster's new collegiate dictionary

Complementary Narcissism Theory: A Family Systems Application of Self Psychology*

HISTORICAL ANTECEDENTS

Prior to the advent of the technological age, the majority of people tended to live as part of extended family groups in well-knit social settings which were relatively isolated and therefore experienced limited threat from outside forces. Any excessive societal injunctions of individuals were intrapsychically repressed or, at worst, resulted in individual protest. People often knew more about being in family than about being themselves. It was in this context Sigmund Freud developed an individualistic psychological theory with individually-oriented interventions.

However, as people responded to the technological age's requirements for relocation, extended family groups were fragmented and uprooted nuclear families with vastly different histories and expectations were thrown together. Meaningful traditions and roots were often lost.

Then, as urbanization increased, an alienated individualism began to emerge, resulting in additional stress on the family unit. In the space of a few generations, people knew less and less how to be family. That bulwark of societal stability, religion, also lost usefulness as the community norms it once assumed fell by the wayside leaving a growing body of individualistic and often short-sighted followers, concrete in their understanding of reality.

Simultaneous to this, children began being born into functionally single parent families with the other parent working long hours away from home. It took only two generations for psychologists to see a trend away from the primarily

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neurotic patient, internally conflicted, to personality disorders founded upon secondary narcissism. The limits of the single parent home and the advantages of extended family of generations past made themselves known.

Families began failing to perform their most basic roles: No longer is it a foregone conclusion that being a part of a family is the most meaningful context in which to experience life; no longer do "good" families necessarily raise "well" children.

Systemic oppression, the dark side of the human condition, rather quickly managed to subvert technology, which could have been a potential godsend for the impoverished masses.

THEORETICAL FOUNDATIONS

As the social compass found north increasingly difficult to evidence, existentialism and phenomenology offered promise to philosophers like Albert Camus, Jean-Paul Sarte, and Martin Heidegger; theologians like Rudolph Bultmann, Paul Tillich, and Dorothee Soelle; sociologists like Erving Goffman, H. Richard Niebuhr, and Emile Durkeim; and change-agents like Herbert Marcuse and Paulo Freire. Based on the assumption that enlightened transcendent, i.e., long-term, self-interest provides the most meaningful life and stable society, early phenomenological psychologies emerged from the likes of Eric Fromm, Carl Rogers, Rollo May, and Victor Frankl. Despite this new direction, psychotherapists were increasingly frustrated that time-proven theories often failed to explain, and trusted interventions were not interrupting the behaviors they were designed to address. Out of this clinical frustration, family therapy and self psychology almost simultaneously emerged.

Family therapy began to be practiced, albeit essentially atheoretically, by psychodynamically informed clinicians like Nathan Ackerman (1958), Murray Bowen (1965), and Henry Dicks (1964). Self psychology, a phenomenological perspective of narcissism, was first and variously described in the work of Heinz Kohut (1966, 1971), Maria Gear, Melvyn Hill, and Ernesto Liendo (1981), and Alice Miller (1979), to name a few who specifically influenced the present paper.

Clinical assimilation of the various methods of family therapy, while maintaining an analytic, self psychology perspective eventually gave rise to Complementary Narcissism's novel system's perspective of the individual in context. While Complementary Narcissism Theory is applicable to all families, its interventions are most effective with those families who evidence a moderate to high ability to delay gratification in service of a larger reward later. Early foundations of this theory may be found in McDonald (1987, 1991, 1992). The data on which this theory is founded is reported elsewhere (McDonald, in press). It is based on a clinical sample of 329 couples and 174 families, and a non-clinical sample of 38 couples and 32 families.

FROM SELF TO SYSTEM

Review. Informing this paper is the understanding that the early developmental line of narcissism, healthy or disturbed, follows two separate but contiguous development lines (Kohut, 1966). One of these is omnipotence, the *idealistic, merger* self whose health in infancy requires its very existence be felt by others as having unlimited influence without any overt effort exerted to obtain that influence. The other developmental line concerns grandiosity, the *ambitious, exhibitionistic* self whose well-being in infancy is reliant upon the acceptance of its performance by others. Following the work of the baby watchers such as Melanie Klein (1948) and other object relations theorists like Donald Winnicott (1971), we now understand each infant fails to receive perfect parenting. To the degree the parenting is not "good enough," a secondary narcissistic injury exists in conjunction with healthy narcissism. Thus narcissistic injury is not a case of present or not present, but is assessed in degree. Either or both the omnipotent and grandiose narcissistic development lines is disturbed to the degree there is a poor goodness-of-fit between the infant and parent figure. Figure 1 illustrates the sequential development which occurs in the infant in each case. Of course, the more stress a person is under, the more apparent will be the nature of the early narcissistic injury, whether omnipotent or grandiose, as we tend to return to type under duress.

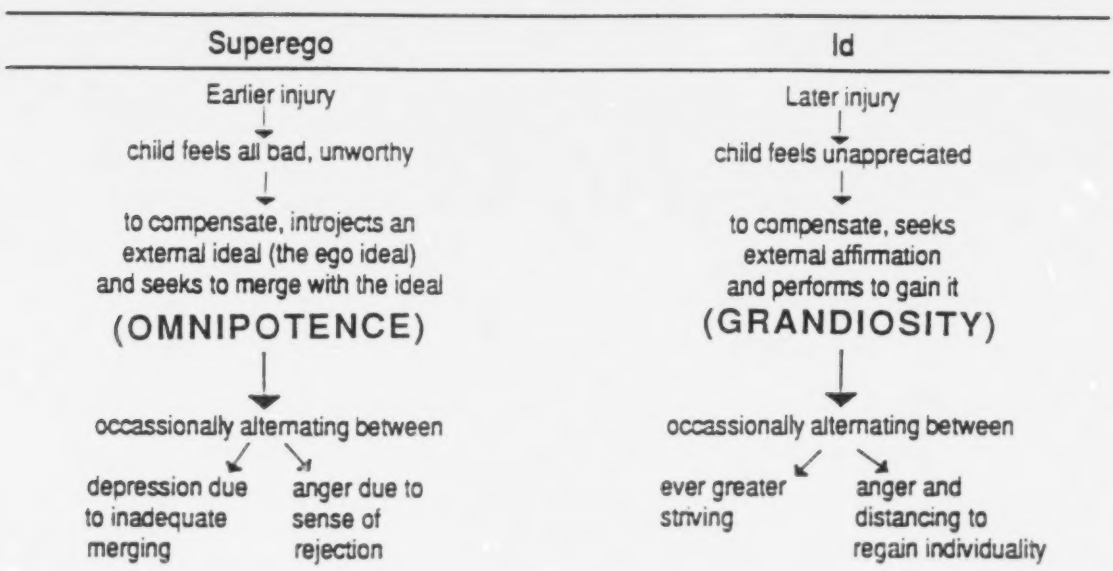
Superego
Id
Earlier injury
child feels all bad, unworthy
to compensate, introjects an external ideal (the ego ideal) and seeks to merge with the ideal
(OMNIPOTENCE)
occassionally alternating between
depression due to inadequate merging
anger due to sense of rejection
Later injury
child feels unappreciated
to compensate, seeks external affirmation and performs to gain it
(GRANDIOSITY)
occassionally alternating between
ever greater striving
anger and distancing to regain individuality

Figure 1. Differential development of narcissism

DSM III R and the two developmental lines of narcissism. Figure 2 illustrates how the degree to which narcissistic injury is present in a specific person predicts and undergirds the degree of personality disorder and/or clinical syndrome.

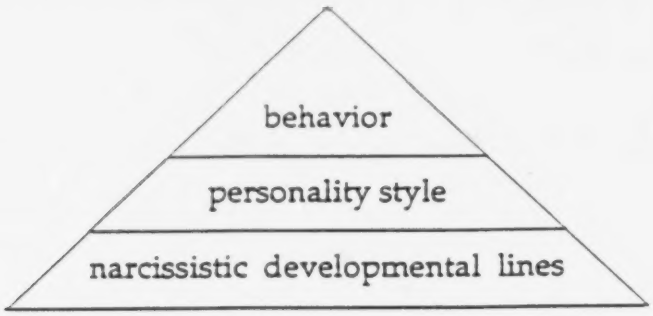

Figure 2. Developmental pyramid

The DSM III R use of the word narcissism is different from narcissism as discussed here: DSM III R focuses on disturbances in the grandiose narcissistic developmental line in its criteria of narcissistic personality disorder. However, it can be seen that all of the DSM III R personality and affective disorders have underlying narcissistic origins and *tend* to be the result of disturbances in the two developmental lines of narcissism as shown in Figure 3:

OMNIPOTENT	TRANSIENT	GRANDIOSE
Avoidant	Borderline	Compulsive
Dependent	Schizotypal	Histrionic
Passive Aggressive		Narcissistic
Schizoid		Paranoid
Self Defeating		Sadistic
Dysthymia	Cyclothymia	
Major Depression		Antisocial

Figure 3. DSM III R and two developmental lines of narcissism

When major depression is added to any personality disorder, any disturbance present in the omnipotent narcissistic developmental line becomes most apparent.

Literary images. History is full of stories of dyads whose narcissism complemented one another. Examples of these include Narcissus and Echo, Anthony and Cleopatra, the Lone Ranger and Tonto. In these cases it is clear that some narcissistic combinations are not good for one another. There are other images of couples, more positive, such as Adam and Eve, Tom Sawyer and Huck Finn, and Harold and Maude. In these latter cases, the complementary qualities tend to in fact make each person more whole (complement) rather than emphasize individual weakness and result in destructive patterns of behavior.

The complementary continuum. Taking these two developmental lines and creating a normal curve for each, one arrives at a bimodal curve for the population. Clinical experience would have us believe approximately half the people fall in the omnipotent category and half the people fall in the grandiose category. Neither one of these is, in and of itself, good or bad, but rather when a person becomes extreme in either direction, a diagnosable intensity is reached and that presentation of narcissism become distorted. Conversely as an individual becomes lower in omnipotence or grandiosity, there is movement toward healthy manifestations of narcissism. The majority of people fall within the first standard deviation and so are moderate in grandiosity or omnipotence. Figure 4 shows an example of the complementary continuum between the two developmental lines of narcissism.

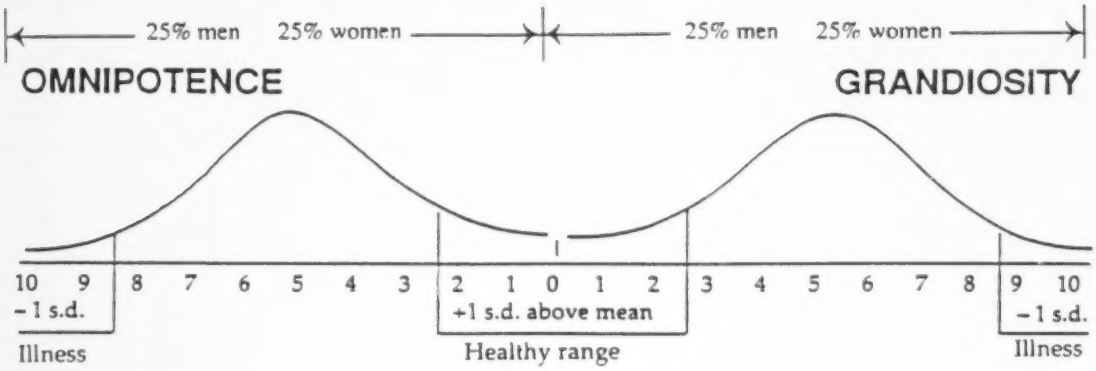

Figure 4. Complementary continuum between two lines of narcissism

In health, omnipotence is influential, grandiosity is impressive. Where omnipotence is idealistic, grandiosity is ambitious. Where omnipotence is a feeling of oneness, grandiosity is a feeling of individuality. The omnipotent person nurtures and follows, where in the grandiose person excites and leads. Omnipotence merges, grandiosity exhibits. Omnipotence is passive, while grandiosity is active. An audience is omnipotent, while the performer is grandiose. These qualities are the positive aspects which come out of healthy manifestations of omnipotence and grandiosity.

Moving away from health, omnipotence can feel obligated while grandiosity can feel entitled. Omnipotence defers while grandiosity demeans. Unhealthy omnipotence is needy and undeserving, while unhealthy grandiosity is aloof and claiming. Omnipotence tends toward depression while grandiosity tends towards impulsive manic states. The excessively omnipotent person tends to feel inferior while excessive grandiosity distorts into superiority. Omnipotence can have a symbiotic quality, while grandiosity can feel autistic. Masochism as an omnipotent presentation finds its complement in sadism, the grandiose presentation. And, finally, extreme omnipotence results in victimhood while unlimited grandiosity leads to tyranny.

In health as well as in dysfunction, omnipotence is a merging with the other

person while grandiosity defines self apart from the other person. Health exists in a person who can be grandiose while remaining connected to the other, and who can be omnipotent while remaining centered. Dysfunction is present in a person whose grandiosity walls others out, and whose omnipotence is felt by others as weighty dependence.

COMPLEMENTARY NARCISSISM THEORY

Basic premises. Individual health requires being relatively low in omnipotence or in grandiosity, and in being able to move, when desired, quickly and smoothly between healthy presentations, i.e. low levels of omnipotence and grandiosity. In this self complementarity, the individual is able to have holistic intrapsychic experience and enter into relationships based upon this strength. Without this capacity, the individual will relate to others who are attracted to dysfunctional presentations of grandiosity and omnipotence, and out of dysfunctional complementarity, rather then out of the strength of intrapsychic wholeness. The approximate healthy range of omnipotence or grandiosity is represented in Figure 5 as the first standard deviation above the population means for omnipotence and for grandiosity.

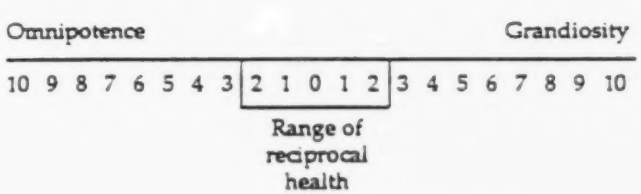

Figure 5.

Marital health is the ability of each spouse to either be the recipient of attention, i.e., allow self to become appropriately grandiose, or to be the giver of

attention, i.e., allow self to move to appropriate omnipotence. Healthy narcissistic complementarity occurs when the spouse with the greater need at the moment receives the attention.

The more flexible yet smooth this reciprocal complementarity is, either between partners, or intrapsychically within one partner, the healthier both the individuals and the marriage are. Reciprocal complementary narcissism is represented in Figure 6.

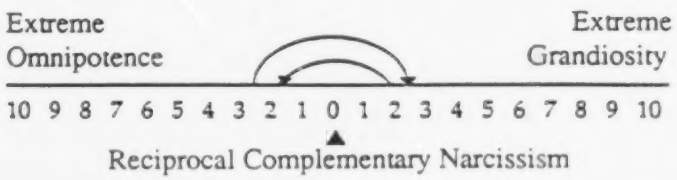

Figure 6.

Referring to Figure 7, whether two people pair as A) omnipotent/omnipotent, B) omnipotent/grandiose, or C) grandiose/grandiose, they will tend to have self-selected the same intensity of narcissism in one another. I.e., extreme narcissism self-selects extreme, just as moderate narcissism self-selects moderate, and low narcissism is attracted to low narcissism.

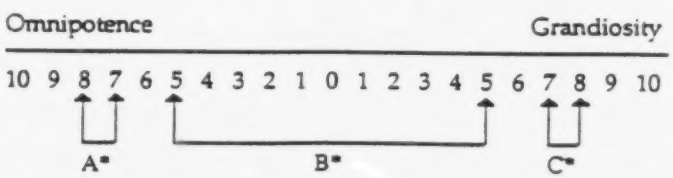

Figure 7.

The universality of this theory lies in the natural tendency of relationships to be a combination of grandiosity and omnipotence. For example, when two people of like narcissism marry, omnipotent/omnipotent or grandiose/grandiose, one

partner will be more omnipotent while the other is more grandiose. However slight this difference is, the narcissistic complementarity remains and, in all but couples with extremely healthy narcissistic presentations, is coerced and emphasized over time. This ever present dichotomy and balance between omnipotence and grandiosity in couples is represented on the Complementary Narcissism Continuum in Figure 8 using an adjustable fulcrum.

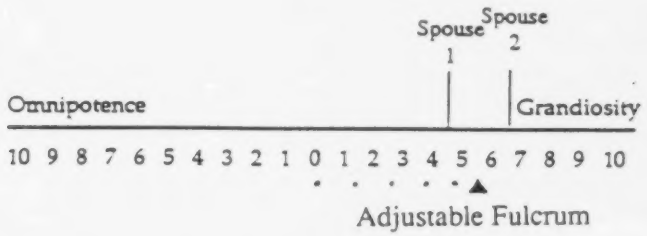

Figure 8.

When a person experiences an extreme narcissistic insult, one of two things may happen. That person may exhibit his or her basic narcissistic injury, grandiose or omnipotent, to a greater extreme, *or* he or she will flip to the complement of the particular narcissistic injury. In the later case, a grandiose person flips to a complementary omnipotent position, and vice versa. The more extreme an individual's narcissism, the more destabilizing will be the flip as the similar extreme complement is quite different. Figure 9 visually illustrates the extent of change occurring intrapsychically in a relatively extreme flip.

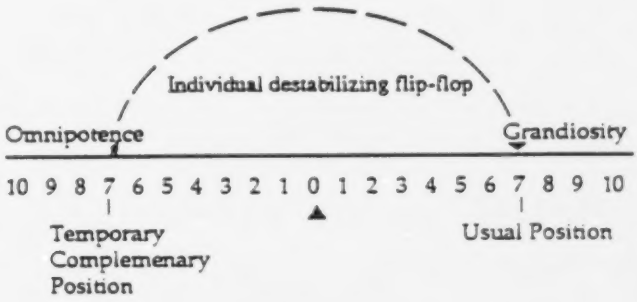
Individual destabilizing flip-flop
Omnipotence
Grandiosity
10 9 8 7 6 5 4 3 2 1 0 1 2 3 4 5 6 7 8 9 10
Temporary Complemenary Position
Usual Position

Figure 9.

The precipitant to the initial therapeutic visit is often an extreme intrapsychic flip occurring in one or both spouses (Figure 10), or in another family member. When two spouses flip, they exchange many narcissistic characteristics and often exchange marital roles. For example, the wage earner may become the homemaker while the homemaker goes into the work force.

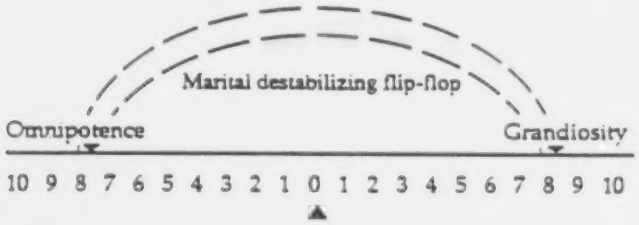

Figure 10.

Whether two low-to-moderate grandiose people marry, or two low-to-moderate omnipotent people marry, or a low-to-moderate grandiose and complementary omnipotent marry, the prognosis is clearly positive because the potential for active, reciprocal complementarity is high. Figure 11 illustrates the approximate marital range for a positive prognosis.

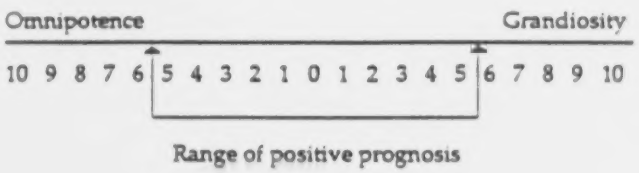

Figure 11.

Conversely, the more extreme spouses are on the Continuum, the less capacity they have to move spontaneously to a narcissistic position which would help complement their spouse's narcissistic need. In addition to having limited capacity to choose to be complementary, such a large move is quite intrapsychically

destabilizing. An example of extreme narcissistic complementarity between two spouses is shown on the Continuum in Figure 12.

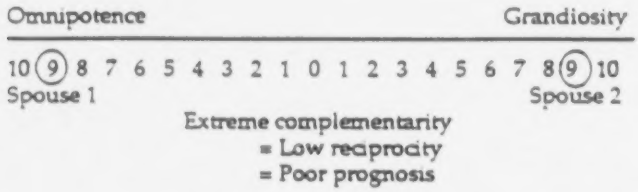
Omnipotence
Grandiosity
10 (9) 8 7 6 5 4 3 2 1 0 1 2 3 4 5 6 7 8 (9) 10
Spouse 1
Spouse 2
Extreme complementarity
= Low reciprocity
= Poor prognosis

Figure 12.

Thus, when two individuals who are more extreme in their omnipotence or grandiosity marry, the prognosis is poor. This holds true even if the partners are extreme toward the same narcissistic pole because the more extreme positions are, the more rigid and unable to move even a small distance to complement the spouse's need. Figure 13 offers a general complementary narcissism prognostic guide.

Complementary Combinations	Intensity	Prognosis
grandiose-grandiose (g-g)	mild moderate severe	good guarded poor
grandiose-omnipotent (g-o)	mild moderate severe	good guarded poor
omnipotent-grandiose (o-g)	mild moderate severe	good guarded poor
omnipotent-omnipotent (o-o)	mild moderate severe	good guarded poor

Figure 13. Prognostic guide

The more extreme an individual's presentation, the more likely he or she are to be, or to have been, the identified patient in the family of origin, neighborhood, or school or work setting. Figure 14 emphasizes not only the large difference between extreme narcissism (represented as "10"), and presentations where complementarity is reciprocal (2 or less), but also the vast difference between an extremely omnipotent person and his or her extremely grandiose complement.

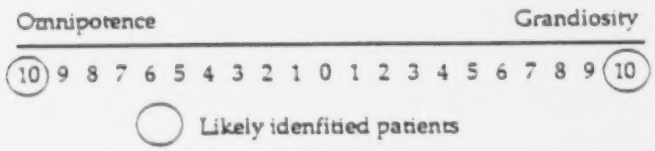

Figure 14.

Assessment. As shown in Figure 15, the first diagnostic goal of Complementary Narcissism Theory is to identify whether the marital couple are both omnipotent, both grandiose, or obviously one omnipotent and the other grandiose. The assessment tool is clinical training and experience including an ability to make dichotomous comparisons like those given earlier on page 6. The interpersonal demands on the clinician using Complementary Narcissism Theory are quite high. As noted before, when the couple is anything other than balanced, one person omnipotent, the other grandiose, the fulcrum of omnipotent and grandiose complementarity moves to a point between the two people. For example, looking at two grandiose people, one is somewhat less grandiose and is coerced into taking the omnipotent role, while the grandiose person is coerced into taking an even more grandiose role. Complementary Narcissism Theory emphasizes the equal contribution a dyad makes to health or to dysfunction.

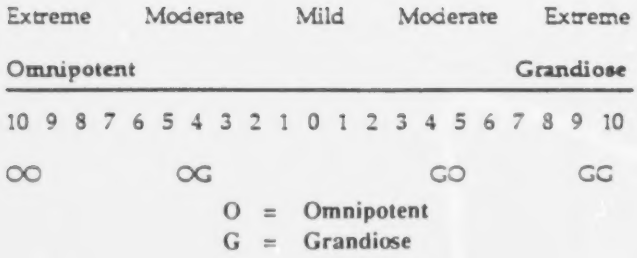

Figure 15. Diagnostic groups

Moving beyond the spouses to the family, the diagnostic questions include: 1) Is this family interacting with their world, i.e., other families, other systems (schools, work, etc.), from an omnipotent or from a grandiose position, and to what degree is there a complementary reciprocity with that world? 2) Is the family splitting one half of its complementary narcissism off into one family member, into an identified patient? 3) Are there triangular relationships requiring two people to complement a third? 4) Are either of the parent's primary complementarities with someone of another generation?

The final formulation needs to summarize how the family's symptom is part of the complementarity, and what would happen if either the symptom were removed, or the complementarities were adjusted appropriately. The more refined yet inclusive the formulation, the more succinct the formulation, the more useful it will be.

Marital Goals. The first goal for the couple is to help those that are extreme on the Continuum move to a more moderate position. Couples who are already in a low to moderate position on the Continuum, or have moved there through prior therapy, can be helped to be, when they desire, more flexible, spontaneous and reciprocal between omnipotence and grandiosity. This enables each spouse to express needs as well as complement their spouse's needs. Figure 16 demonstrates this move to a milder presentation and the capacity for reciprocity.

Figure 16. Marital goals

Family Goals. When there is an identified patient in the family, the first goal is to help the family own the negative characteristics if they are splitting off from themselves and projecting into the identified patient. These will likely take the form of the family seeing one of the presentations of narcissism as healthy and the other as bad, putting the identified patient at the end of the Continuum which is bad; or, in healthier families, reserving the healthy presentations of both developmental lines, omnipotence and grandiosity, for themselves and forcing the identified patient to manifest the more negative qualities of omnipotence and grandiosity. Another goal is to facilitate reciprocal omnipotent/grandiose interaction between the various dyads in the family. Intervention in complementary triangulation is another goal; Figure 17 illustrates triangular complementarity using the Continuum. Intervention is also required when an individual parent's primary omnipotent/grandiose reciprocity is with a child, i.e., crosses the generational boundaries.

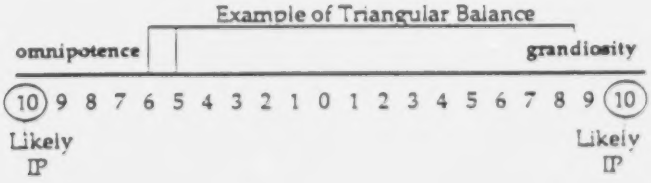

Figure 17. Triangular Complementarity

Tactics. There are several routine interventions to achieve reciprocal complementary narcissism in a family. One of these is to teach the concept using terms customized to this specific family as necessary to replace the terms omnipotent and grandiose. Additionally, each patient needs to know what the healthy manifestations of grandiosity and omnipotence are for him or her. This might be done if these terms are perceived as pejorative or just too difficult to grasp. In these cases, for example, nurturing and exciting might replace omnipotent and grandiose respectively. The concept of complementary narcissism can be made more experience-near by using each family member's previously elicited informing images of life to illustrate the concept. To facilitate the learning process, the Continuum can be drawn out on newsprint in the therapist's office marking each family member's approximate position. Comparing this therapist's assessment with their subjective perceptions of themselves and each other, as well as further defining terms with a few synonyms individualized to these patients is a reality testing exercise. The newsprint Continuum can be given to the family at the end of the session to post in their home for reference during the week. To increase discussion, each family member can be given a weekly handout for daily charting their own omnipotent or grandiose intensity, as well as that of other family members. During sessions, family dyads can practice reciprocal complementarity wherein one talks, the other listens and then the former listens while the latter talks.

Analytic interventions rely on the therapist's use of self; while the discussion of Complementary Narcissism Theory to this point has been "operationalized" to the point of diagrams and sequential logic, it is crucial to the theory and therapy that psychodynamic basics and the on-going theorizing in self psychology be familiar to the therapist. For example, understanding the self psychology concept of narcissistic supplies offered to patients through the therapist's correct "empathic attunement," is essential to the correct application of the theory.

Common Clinical Errors. Narcissism is not an easy thing to grasp. It is a current cutting edge in the psychoanalytic world. Almost a hundred years of clinical work and theorizing passed before narcissism's nuances were sufficiently grasped to

make new inroads into what is now known as self psychology. For this reason, it takes longer to make the assessment and formulation than with other theories, and it takes longer to train therapists in the use of it. There are several typical clinical errors which have been noted in trainees:

- Very often the therapist forgets that both omnipotent and grandiose presentations are part of everyone's narcissistic developmental line and the foundation of the human condition.
- It is very easy to misidentify people who seem to vacillate between extremes of omnipotence and grandiosity.
- The "false self" presentation described by Winnecott is easy to misidentify wherein the person typically presents as a complement to their true self; in other words, a person whose narcissism is actually grandiose presents as omnipotent. Ruling out stonewalling and game playing presentations of narcissism can help identify false self presentations.
- The therapist will often mistake grandiosity for health when compared to omnipotence or visa versa depending upon the therapist's own position on the Continuum. In other words, it is important the therapist be able to apply the theory to his or her self. Congruent with this last error, it is easy for the therapist to mistake an omnipotent partner as lower functioning compared to the grandiose partner or visa versa depending upon the therapist's own narcissistic position.
- All too often, a depressed grandiose person is diagnosed with an anxiety disorder only, while the underlying affective disorder goes untreated. Similarly, it is easy at times to assess a grandiose family member as omnipotent or an anxious omnipotent family member as grandiose.
- Therapists often fail to anticipate the depression which a grandiose person must go through to become less grandiose. Likewise the depression that the omnipotent person must struggle with as they become less omnipotent may come as a surprise.
- Because of the compelling dynamics in the grandiose/omnipotent dichotomy, family members' capacity for reciprocal complementary narcissism may not be clear unless their functioning in other contexts is taken into account.

• Finally, it is easy to miss collusion between several family members that is protecting another family member having extreme grandiose or omnipotent tendencies.

MULTIPLE THEORY ASSESSMENTS

Consistent with analytic family psychologies (e.g., Bentovim and Kinston, 1991) this approach goes beyond the family's presenting complaint, the precipitant, and specific behaviors, to understand the etiology of the individuals and of the family itself. At the same time as the origin of a family system is describing the way individuals and their histories influence the system, data is being gathered concerning the influence of the present family of creation, once formed, on the individuals.

The multiple theory assessments require two sequential stages. The first involves ten steps and describes the family both in analytic and systems terms. This first stage is eclectic in that it assumes a specific family and its individuals will be described better in the language of one perspective than another (Henle, 1965). Caution is taken not to lose the primary aspects of various theories through mixing them. For example, some family's systems can be better described in terms of communication than in the language of structure, or visa versa. And, likewise some individual's differentiation suffers more from their ego strength (Blank & Blanck, 1974; 1979) than from their object relations (Blanck & Blanck, 1986; Scharff, 1989), or visa versa.

The second stage specifically addresses the complementary narcissism assessment procedure previously discussed. That assessment cannot be rushed, it requires time spent interacting with the family. The time required to make the complementary assessment and formulation is simultaneously used to make any immediately obvious interventions.

INITIAL ASSESSMENT: TEN STEPS

Step One. The therapist begins to feel each family member's availability for relationship. One of the assessment tools here is the therapist's use of self to intuitively know each individual's object relations (Blanck & Blanck, 1986; Scharff, 1989; Slipp, 1984). This includes their mental status, their capacity for empathy and ability to be assertive. Availability for relationship can be felt in terms of the thin gossamer thread between self and other, as well as among others.

Step Two. The immediate life stressors for the individuals and for the family are identified. These need to be placed in context in the therapist's mind in terms of intensity, duration, and societal norms. The nature of the immediate precipitant motivating the family to seek help at this time will help the therapist understand the degree of dysfunction and/or instability in which the family lives. For example, if a family system breaks down over a minor stressor, the implication is that either the system was already too stressed, or that it is quite ineffective, or both.

Step Three. Each family member's effectiveness at achieving universal goals, daily goals, and interpersonal objectives is noted. This ego assessment will help the therapist differentiate between script-based, superego-motivated successes and genuine, creative ego strength (Blanck & Blanck, 1974; 1979).

Step Four. Using the data gathered to this point, conscious and unconscious, the therapist develops a preliminary understanding and feeling about each family member's sense of self. This requires a phenomenological approach, one where the therapist puts aside assumption and bias to experience life from each family member's perspective, assumptions and biases. This self assessment will be continually reviewed for reliability and validity, with adjustments made as necessary.

Step Five. The therapist now compares the current availability of each adult family member's relationship (Step One) with that respective member's premarital level. This also applies to children in step families and blended families - is the child's current circle of trust larger or smaller then it was in the original family? A comparison of premarital reaction to life stressors (and pre-step family or pre-

blended family, as applies) is made with current reactions (Step Two).

Step Six. As the family presents their issues, the therapist gleans dynamic relational history on each family member, with a goal of eventually arriving at the traumatic etiology of any current dysfunction, as well as any family-of-origin era relationships which could be sources of strength or healing. How the individual currently acts out the historical, relational trauma is one of the therapist's constant questions, as is how the acting out of individuals limits complementary narcissism in specific other family members. Also coming out of the psychodynamic history will be a sense of individual's developmental level and prognosis.

Step Seven. In tandem with the relational dynamic history (Step Six), the family system's usefulness to the improvement of each individual's complementary narcissism is assessed, with notes made about specific identified blocks.

Step Eight. If no immediate, common behavioral intervention is indicated, nor is a simple response such as referral, the therapist proceeds with a three generation genogram and systems assessment. This aspect of the assessment needs to describe the family's strengths and weaknesses in terms of general systems concepts. Figure 18 shows the General Systems Scale which helps insure the therapist's countertransference will have minimal impact on assessment thoroughness.

	Oppressive to Individuals	Benign to Individuals	Complementary to Individuals
ORGANIZATION			
Boundaries	Fragmented or impermeable	Passively open	Actively open yet intact
Alliances	Severe triangulation, isolation, and/or hierarchies	Minimal isolating	Mature affection and cooperation
Wholeness	Each person constrained or dependent on other persons	Each person conditioned by other person	Persons are interdependent
CONTROL			
Communication	Unreciprocal and/or gaming	Understandable majority of time	Appropriate reciprocal self-disclosure
Competence	Action is absent or destructive	Action is adequate or benign	Action is consistently realistic
Adaptability	Rigid or chaotic without stressor	Stable with minimal fragmentation under stress	Creatively flexible and consensual
ENERGY			
Affect	Entropy (over or under emotional involvement	Stable and appropriate expression majority of issues and time	Consistent negentrophy reciprocal empathy without manipulation
TIME - Process (developmental)	Family life stages compromised or arrested	Minimum family life changes achieved	Advanced family life stage development

Figure 18. General Systems Scale

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Step Nine. At this point in the assessment, the therapist has enough data to know how each individual complements, contributes to or detracts from, the family system. This data considers, among other things, each individual's etiological trauma hypothesis (Step Six), and the systems assessment (Step Eight).

Step Ten. The therapist at this time has sufficient information to articulate the system's basic complementarities and even informing images of those complementarities to which the whole family can relate. The informing images may come later but need to be present in the therapist's mind as the complementary narcissism formulation is finalized.

INITIAL FAMILY FORMULATION

While continuing to gather data for the complementary narcissism formulation, the therapist takes into account individual dynamics and trauma, the system's history and formulates an initial hypothesis. The use of the family time-event graph in Figure 19 helps organize the shear quantity of data being considered.

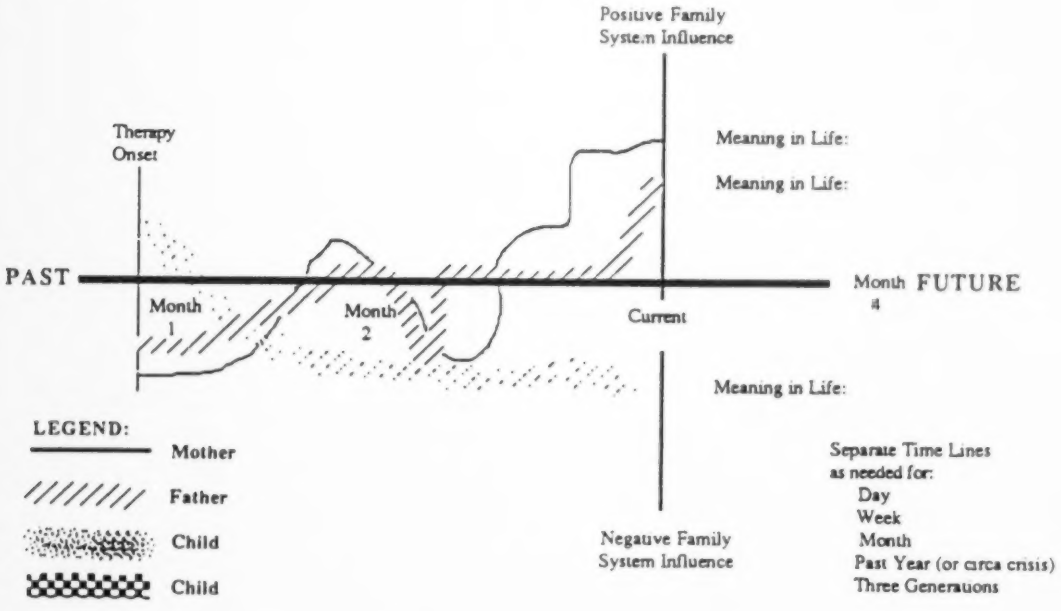

Figure 19. Family time-event graph

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by the therapist and makes significant patterns readily identifiable.

First, the linear logic of the initial formulation requires the presenting complaint (identified patient or symptom) be seen as a function of both the family and all individuals in the family. Next, the family's fears about interrupting the symptom or ceasing to identify one family member as patient are determined.

The family system's informing script can usually be summarized in one emotionally memorable event from the family history. When this image can be provided to the family, their resistances to change can be regularly addressed in terms of the informing image.

INITIAL INTERVENTIONS PROCESS

Pre-complementary narcissism interventions are prioritized on a behavioral-dynamic continuum, as well as on an immediate needs - long term needs continuum. Typically, the family's goal concerns symptomatic relief, while the therapist's agenda takes into account deeper seated issues and needs including life cycle development, socio-economic status, and history. The therapist must resist moving too quickly on the family's agenda, lest the real problems become masked. Waiting to intervene is weighed against the possible harm of letting the symptom continue for the time being.

Throughout the therapy, data collection and assessment continue and inform the formulation. Behavioral interventions such as providing fair-fighting rules or behavior re-enforcement charts, are provided immediately if it is deemed potentially destructive to wait. Premature interventions that may result in inadequate or inaccurate formulation are avoided.

Behavioral, cognitive and systems interventions follow, addressing dangerous acting out, denial, repetitive patterns, communications, structures, and differentiation.

Individual personalities are addressed by accurately reflecting each patient's inner experience, then interpreting his or her narcissistic vulnerabilities (this is not

the case when borderline diagnosis is present). The best therapy occurs when the therapist can do this in such a way as to model the reflecting process to the edification of other family members.

A move is made back to the system, its assets and dysfunctions. The therapy continues to move between individuals and system until sufficient data is present to make the complementary narcissism assessment; typically, the complementary narcissism assessment comes after a minimum of four sessions.

To summarize the first four sessions: There is ongoing data collection and assessment. The family's response to the last session, especially resistance and defenses, is discussed. Interventions are aimed at triangles, boundaries and other issues on the General Systems Scale. Modeling is an ongoing task of the therapist - especially nurturing, empathic attunement, and communication skills. The "here and now" experience and sense of relating are emphasized by teaching and action. Assignments between sessions keep both the therapist and family on task and accountable.

Data, assessments, and events which effect the formulation, and therefore effect future interventions, are recorded in SOAP notes at the end of each session. The SOAP note has four paragraphs, one each for the patients' Subjective experience, the patients' report of measurable Objectives, continuing Assessment, and future Plans.

COMPLEMENTARY NARCISSISM ASSESSMENT

As the therapist comes to feel the individual's and the family narcissism, in addition to identifying the complementary isolates, dyads, triads and crossed boundaries, the complementary narcissism assessment is made. All individual and system dysfunctions previously made are now also understood in complementary narcissism systems concepts.

The complementary narcissism formulation is derived from both the initial family formulation and the complementary narcissism assessment. The final goal

of this formulation is an exceedingly clear, concise statement which summarizes the complementary system, and implies a corrective plan to move the family and its members toward their potential. The ideal outcome must be clear in the therapist's mind.

COMPLEMENTARY FORMULATION.

As the data becomes available, the clinician fills out an Individual Assessment Comparison Chart; a completed hypothetical example is shown in Figure 20. The ways that this sample couple complement one another can be to range from behavioral to narcissistic. The extent to which this particular couple is functional is due, as is so often the case, to stabilizing superego - however oppressive and intimacy-inhibiting those superegos may otherwise be. It is worth

Area of Assessment	Sample Mother	Sample Father
Object relations	object - object	isolated and selfobjects
Interpersonal style	goal oriented (assertive to aggressive)	reclusive (passive aggressive to withdrawn)
Primary defenses	repression and reaction-formation	isolation (at times schizoid)
Ego strength	high superego discipline	superego injunctions
Script	"I come from a long line of strong women"	"You wouldn't want to know me"
Foundational fear	abandonment	not being fed
Sense of self	shameful	superior
Primary narcissistic presentation	adaptive (omnipotent)	withdrawn (grandiose)
Dysfunctional complementary narcissistic presentation	aggression (grandiose)	dependency (omnipotent)

Figure 20. Individual assessment comparison chart

repeating that healthy omnipotence has a powerful, merging quality while retaining a sense of self, and healthy grandiosity involves taking the stage while remaining connected to the audience. Conversely, *un*healthy omnipotence merges with others to the point it loses its identity, while *un*healthy grandiosity stands apart to the point that any sense of connection with the other person(s) is lost.

All of the complementary alliances within the client family are now prioritized clinically and placed on the Complementary Alliances Chart. This is demonstrated in Figure 21 using a hypothetical family consisting of mother father, daughter, and son.

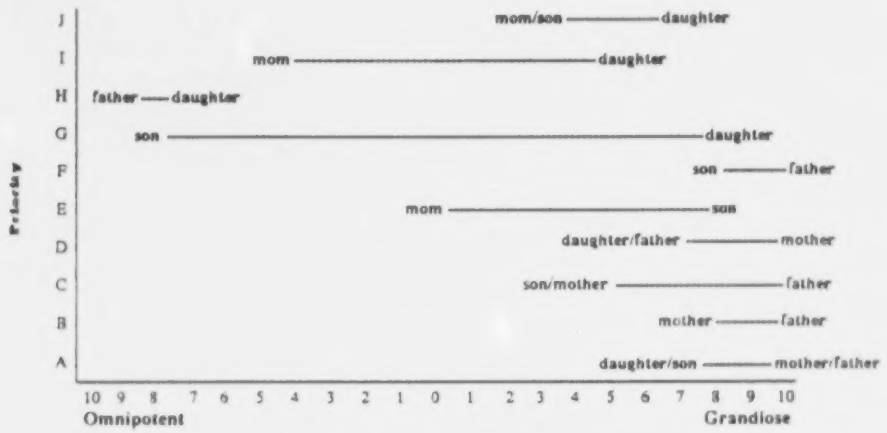

Figure 21. Prioritized complementary alliances chart

At this point, the complementary narcissism formulation is summarized. A sample summary using the hypothetical family follows:

> Cyclically the two younger children re-engage the parents back into the family either by the son acting out extreme grandiosity (truancy), or by the daughter moving to extreme omnipotence (depression). In addition, these two children, narcissism polarized with one another complementally, are responsible for diminishing the hatred between their respectively polarized parents by fighting viciously with one another.

Out of the complementary narcissism formulation comes a clearer sense of the overall goals that will benefit this hypothetical family. The goals can be summarized as follows:

> The parent's respective narcissism will lessen to the point that reciprocal narcissistic complementarity is possible between them. This improved union will inhibit cross boundary alliances and splitting with the children. The father will do more with the family and the mother will move from her angry caretaker role to genuine nurturing. The children will then be freer to continue their intrapsychic and interpersonal complementary narcissistic growth.

Now the clinician is ready to make all interventions in light of complementary narcissism theory from directive behavioral assignments, to cognitive reframing, to analytically-informed interpersonal therapy.

References

Ackerman, N.W. (1958). **The psychodynamics of family life.** New York: Basic Books.

American Psychiatric Association (1987). **Diagnostic and statistical manual of mental disorders (3rd ed. revised).** Washington, D.C.: Author.

Beck, A.T., Freeman, A, & Associates (1990). **Cognitive therapy of personality disorders.** New York: Guildord Press.

Bentovim, A. & Kinston, W. (1991). Focal family therapy: Joining systems therapy with psychodynamic understanding. In A.S. Gurman & D.P. Kniskern (Eds.) **Handbook of family therapy, volume II.** New York: Brunner Mazel. 284-324.

Berne, E. (1961). **Transactional analysis in psychotherapy.** New York: Grove Press.

Berne, E. (1964). **Games people play.** New York: Ballantine.

Blanck, R. & Blanck, G. (1974). **Ego psychology: theory and practice..** New York: Columbia University.

Blanck, R. & Blanck G. (1979). **Ego psychology II: psychoanalytic developmental psychology.** New York: Columbia University.

Blanck R. & Blanck G. (1986). **Beyond ego psychology: Developmental object relations theory.** New York: Columbia University.

Bowen, M. (1956b). Intrafamily dynamics in emotional illness. In: A. D'Agnostino (Ed.), **Family, church, and community.** New York: P.J. Kennedy & Sons.

Dicks, H.V. (196?). Concepts of marital diagnosis and therapy as developed at the Tavisfock Family Psychiatric Clinic, London, England. In E.M. Nash, L. Jessner, & D.W. Abse (Eds.), **Marriage counseling in medical practice.** Chapel Hill: University of North Carolina Press.

English, H.B., & English, A.C. (1958). **A comprehensive dictionary of psychological and psychoanalytic terms.** New York: Longmans, Green and Co.

G & C Merriam Co. (1963). **Webster's seventh new collegiate dictionary.** Springfield, MA: Author.

Gear, M.C., Hill, M.A. & Liendo, E.C. (1981). **Working through narcissism.** New York: Aronson.

Henle, M. (1957). Some problems of ecclectism, **Psychological review, 64,** 5.

Klein, M. (1948). **Contributions to psychoanalysis.** London: Hogarth Press.

Kohut, H. (1966). Forms and transformations of narcissism. **Journal of the American Psychoanalytic Association, 14,** 243-272.

Kohut, H. (1971). **The analysis of the self.** New York: International Universities Press.

McDonald, C.D. (1987). Associations between Type A personality and narcissism: A psychodynamic exploration. (Doctoral dissertation, Boston University). **Dissertation abstracts international 48,** 2B.

McDonald, C.D. (1991). Clarifying several nuances of narcissism and their implications for pastoral care. **The journal of pastoral care, 45,** 149-156.

McDonald, C.D., Weston, L.B., Hayes, D. J., & Ligon, R. (1992). **Helpful either/or psychological, theological, and medical paradigms for family therapy.** A Symposium presented at the 100th Annual Convention of the American Psychological Association, Washington, D.C.

McDonald, C.D. (in press). Contributions of self theory to family psychology **The family psychologist.**

Miller, A. (1979). Depression and grandiosity as resulted forms of narcissistic disturbances. **International review of psychoanalysis 6**, 61-76.

Scharff, J.S. (1989). **Foundations of object relations family therapy.** Northvale, NJ: Jason Aronson, Inc.

Simon, S.B., Howe, L.W., & Kirschenbaum, H. (1972). **Values clarification.** New York: Hart Publishing.

Slipp, S. (1984). **Object relations: a dynamic bridge between individual and family treatment.** New York: Jason Aronson.

Winnicott, D. (1971). Transitional objects and transitional phenomena, **Playing and reality.** New York: Basic Books, 1-25.